

## PATIENT INFORMATION

When registering, please present proof of insurance, Medicare and/or Medicaid. Payment is expected at the time of service unless special arrangements are made.

### ***PATIENT INFORMATION***

---

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
Driver's License Number: \_\_\_\_\_ State: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Student: Y N Referred by: \_\_\_\_\_

### ***PATIENT'S EMPLOYER***

---

Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

### ***PATIENT'S SPOUSE/GUARDIAN***

---

Spouse/Guardian: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

### ***RESPONSIBLE PARTY*** (if other than patient)

---

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Emergency Contact (not living with you): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I authorize the release of any medical or other information necessary to process this claim. I also request payment of claims to be paid to Pulmonary Associates of Brandon.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



SMOKING: Do you smoke? \_\_\_\_\_ Have you ever? \_\_\_\_\_  
How many total years? \_\_\_\_\_ How many packs per day? \_\_\_\_\_  
Have you quit? \_\_\_\_\_ When? \_\_\_\_\_

ALCOHOLIC BEVERAGES: Do you drink? \_\_\_\_\_ How many drinks per day? \_\_\_\_\_  
Beer? \_\_\_\_\_ Wine? \_\_\_\_\_ Liquor? \_\_\_\_\_

HOUSEHOLD PETS: Do you have pets at home? \_\_\_\_\_ Indoor or outdoor? \_\_\_\_\_  
Please list them (dog, cat, bird, etc.): \_\_\_\_\_  
\_\_\_\_\_

HOBBIES: Please list your hobbies and recreational activities:  
\_\_\_\_\_  
\_\_\_\_\_

When was the last time you had the following test (approximate date or year):  
TB Skin Test \_\_\_\_\_ EKG \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Breathing Test \_\_\_\_\_

MEDICATIONS (please list all medications, including vitamins, aspirin, birth control pills, Tylenol, etc.):

Current:

Name/Strength	Reason Taken	How Often	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Last Six Months:

Name/Strength	Reason Taken	How Often	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Are you allergic to medications? \_\_\_\_\_ What reaction do you have?  
Medications: \_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_

Other Allergies (eggs, dust, animals, etc.): \_\_\_\_\_

Please check appropriate space if you have had any of these illnesses:

CHILDHOOD: Rheumatic Fever \_\_\_\_\_ Mumps \_\_\_\_\_ Asthma \_\_\_\_\_  
Scarlet Fever \_\_\_\_\_ Measles \_\_\_\_\_ Other \_\_\_\_\_

ADULT: Glaucoma \_\_\_\_\_ Stroke or Paralysis \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_ Diabetes \_\_\_\_\_  
Stomach Ulcers \_\_\_\_\_ Arthritis \_\_\_\_\_  
Hepatitis/Jaundice \_\_\_\_\_ Gout \_\_\_\_\_  
Cirrhosis of Liver \_\_\_\_\_ Thyroid Disease \_\_\_\_\_  
Colitis \_\_\_\_\_ Anemia \_\_\_\_\_  
Diverticulitis \_\_\_\_\_ Tuberculosis \_\_\_\_\_  
Gallstones \_\_\_\_\_ Hay Fever \_\_\_\_\_  
Pancreatitis \_\_\_\_\_ Pneumonia \_\_\_\_\_  
Kidney Stones \_\_\_\_\_ Pleurisy \_\_\_\_\_  
Gonorrhea/Syphilis \_\_\_\_\_ Bronchitis \_\_\_\_\_  
Depression \_\_\_\_\_ Emphysema \_\_\_\_\_  
Nervous Breakdown \_\_\_\_\_ Heart Disease \_\_\_\_\_  
Epilepsy/Seizures \_\_\_\_\_ Cancer \_\_\_\_\_

HOSPITALIZATIONS AND SURGERIES (please list all your hospitalizations and surgeries):

19 \_\_\_\_\_ Reason \_\_\_\_\_ Doctor/Hospital \_\_\_\_\_  
19 \_\_\_\_\_ Reason \_\_\_\_\_ Doctor/Hospital \_\_\_\_\_  
20 \_\_\_\_\_ Reason \_\_\_\_\_ Doctor/Hospital \_\_\_\_\_  
20 \_\_\_\_\_ Reason \_\_\_\_\_ Doctor/Hospital \_\_\_\_\_  
20 \_\_\_\_\_ Reason \_\_\_\_\_ Doctor/Hospital \_\_\_\_\_

FAMILY HISTORY: Father Living \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ Age \_\_\_\_\_  
Illnesses \_\_\_\_\_ Cause of Death \_\_\_\_\_  
Mother Living \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ Age \_\_\_\_\_  
Illnesses \_\_\_\_\_ Cause of Death \_\_\_\_\_

List the name, living, age, and illnesses:

BROTHERS: \_\_\_\_\_ SISTERS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check if any of your blood relatives have had any of the following:

Asthma \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Epilepsy \_\_\_\_\_  
Emphysema \_\_\_\_\_ Heart Disease \_\_\_\_\_ Cancer \_\_\_\_\_  
Bronchitis \_\_\_\_\_ Stroke \_\_\_\_\_ Hay Fever \_\_\_\_\_  
Tuberculosis \_\_\_\_\_ Arthritis \_\_\_\_\_ Anemia \_\_\_\_\_  
Diabetes \_\_\_\_\_ Gout \_\_\_\_\_ Other: \_\_\_\_\_

REVIEW OF SYSTEMS (If you have had any of these symptoms within the last 6 months, please put a check by them. If you are unsure, please put a ?):

Weight \_\_\_\_\_ Have you gained or lost over 10 pounds in the past year? \_\_\_\_\_

**SKIN**

- \_\_\_\_\_ Chronic skin irritation
- \_\_\_\_\_ Lump or growth
- \_\_\_\_\_ Change in skin color
- \_\_\_\_\_ Skin cancers

**EYES**

- \_\_\_\_\_ Glasses
- \_\_\_\_\_ Change in vision
- \_\_\_\_\_ Pain in eyes
- \_\_\_\_\_ See halo around lights

**EARS**

- \_\_\_\_\_ Trouble hearing
- \_\_\_\_\_ Earaches
- \_\_\_\_\_ Discharge from ears
- \_\_\_\_\_ Buzzing or ringing in ears

**NOSE AND THROAT**

- \_\_\_\_\_ Frequent sneezing
- \_\_\_\_\_ Nose continually stuffy or runny
- \_\_\_\_\_ Frequent sore throats
- \_\_\_\_\_ Hoarseness

**BREAST**

- \_\_\_\_\_ Lump
- \_\_\_\_\_ Discharge
- \_\_\_\_\_ Pain

**HEART AND LUNG**

- \_\_\_\_\_ Chest pain with activity
- \_\_\_\_\_ Other chest pain
- \_\_\_\_\_ Shortness of breath
- \_\_\_\_\_ Sleep with more than one pillow to help you breathe
- \_\_\_\_\_ Blood in sputum
- \_\_\_\_\_ Wheezing
- \_\_\_\_\_ Unusual heartbeat
- \_\_\_\_\_ Heart attack
- \_\_\_\_\_ Swollen ankles

**GENERAL**

- \_\_\_\_\_ Loud snoring
- \_\_\_\_\_ Unusual fatigue
- \_\_\_\_\_ Unusual weakness
- \_\_\_\_\_ Swollen lymph glands
- \_\_\_\_\_ Fever in past month
- \_\_\_\_\_ Night sweats

**ENDOCRINE**

- \_\_\_\_\_ Frequent urination
- \_\_\_\_\_ Unusual thirst

**GENITOURINARY**

- \_\_\_\_\_ Painful urination
- \_\_\_\_\_ Frequent urination
- \_\_\_\_\_ Blood in urine
- \_\_\_\_\_ Discharge from vagina or penis
- \_\_\_\_\_ Blood or pus in urine
- \_\_\_\_\_ Difficulty starting urinating

**MUSCULOSKELETAL**

- \_\_\_\_\_ Painful joints
- \_\_\_\_\_ Sore muscles
- \_\_\_\_\_ Back pain
- \_\_\_\_\_ Unusual weakness

**NEUROPSYCHIATRIC**

- \_\_\_\_\_ Frequent or severe headaches
- \_\_\_\_\_ Dizziness or fainting
- \_\_\_\_\_ Depressed
- \_\_\_\_\_ Convulsions/epilepsy

**LUNGS**

Shortness of breath:

- \_\_\_\_\_ at rest
- \_\_\_\_\_ walking uphill or upstairs
- \_\_\_\_\_ walking level with others your own age
- \_\_\_\_\_ walking level at your own pace
- \_\_\_\_\_ washing or dressing

How far can you walk without stopping? \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_

What type? \_\_\_\_\_

**STOMACH AND LIVER**

- \_\_\_\_\_ Frequent heartburn/indigestion
- \_\_\_\_\_ Frequent nausea or vomiting
- \_\_\_\_\_ Stomach pain
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Bleeding ulcers
- \_\_\_\_\_ Hemorrhoids
- \_\_\_\_\_ Blood in bowel movements
- \_\_\_\_\_ Loss of appetite
- \_\_\_\_\_ Vomiting blood
- \_\_\_\_\_ Black bowel movements

REVIEW OF SYSTEMS (If you have had any of these symptoms, please put a check by them. If you are unsure, please put a ?):

COUGH:

Do you usually cough first thing in the morning? \_\_\_\_\_  
Do you usually cough after going to bed at night? \_\_\_\_\_  
Do you cough every day for at least three months out of the year? \_\_\_\_\_  
How many years have you had this cough? \_\_\_\_\_  
Do you bring up phlegm or sputum with your cough? \_\_\_\_\_ What color? \_\_\_\_\_  
How much phlegm do you usually bring up in a 24-hour period? \_\_\_\_\_ (tsp, tbs, cup)  
Have you ever coughed up blood? \_\_\_\_\_ If yes, when? \_\_\_\_\_  
Did you see a doctor about this? \_\_\_\_\_ Did you get an x-ray? \_\_\_\_\_

WHEEZING:

Have you ever noticed whistling or wheezing in your chest? \_\_\_\_\_  
How frequently (circle one):                      Daily              Weekly              Monthly              After Colds Only  
Is your wheezing more common during any particular season? \_\_\_\_\_  
Which season? \_\_\_\_\_  
Is your wheezing related to any of the following? (circle all that apply)  
House Dust                      Animals                      Deep Breaths                      Cough  
Meals                      Skipping Meals                      Moving Arms  
How many years have you had this chest pain? \_\_\_\_\_

ASTHMA:

Have you ever had asthma? \_\_\_\_\_  
Have you ever gone to the emergency room for your asthma? \_\_\_\_\_  
How often do you have an attack? \_\_\_\_\_  
Do you have polyps in your nose? \_\_\_\_\_

SINUSES:

Do you frequently have postnasal drip? \_\_\_\_\_  
Do you frequently have tenderness over your cheekbones? \_\_\_\_\_  
Have you ever had surgery on your sinuses? \_\_\_\_\_  
Have you ever had the following? (check all that apply)  
\_\_\_\_\_ Frequently waking at night with an acid or sour taste in your mouth  
\_\_\_\_\_ Waking up with a sore throat in the morning  
\_\_\_\_\_ A burning chest pain that goes into your throat, especially when you lie down

# PULMONARY ASSOCIATES OF BRANDON

## Florida Sleep Disorder Center

Richard S. Powell, M.D.  
Daniel G. Lorch, M.D.\*  
Thomas P. Hooker, D.O.  
Arthur E. Graves, M.D.  
Suketu K. Shah, M.D.\*  
Barbara E. Quigley, ARNP



Pulmonary Diseases  
Sleep Disorders  
Critical Care  
Internal Medicine

*Diplomat : American Board of Pulmonary Disease; Critical Care; Internal Medicine, Sleep Medicine\**

## ASSIGNMENT OF BENEFITS

In consideration of Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon services rendered or to be rendered, I assign and transfer any interest in any cause of action to Florida Sleep Disorder Center at Brandon any benefits payable to or for my benefit under my medical insurance policy for payment of services rendered. I agree to fulfill all policy provisions such insurance companies may require for payment. I authorize Florida Sleep Disorder Center at Brandon to initiate a complaint to the insurance commissioner for any reason on my behalf.

I authorize Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon to release any medical information pertaining to my diagnosis and to/or treatment, including laboratory test results, medical history, treatment progress, or any other such related information to: (1) representatives of local, state, or federal agencies in accordance with law; (2) my insurance company or its designated representative; and/or (3) any person(s) or entities financially responsible for my care and treatment. I understand this information may be required to be released in order to obtain payment for my medical expenses incurred at Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon.

I understand that if I receive payment from my insurance company for services rendered by Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon, I am obligated to promptly reimburse Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon for the full amount that I receive. If collection action must be taken to reimburse this facility for misappropriated funds owed Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon, I will be held liable for all charges billed to my insurance company as well as any legal fees incurred.

I, THE UNDERSIGNED, PATIENT OR PATIENT REPRESENTATIVE, HAVE READ AND UNDERSTAND THIS INFORMATION.

\_\_\_\_\_  
Patient/Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

910 Oakfield Drive, Suite 102 ▪ Brandon, Florida 33511 ▪ Phone (813) 681-4413 ▪ Fax (813) 681-6429  
4051 Upper Creek Drive, Suite 106 ▪ Sun City Center, Florida 33573 ▪ Phone (813) 634-7033 ▪ Fax (813) 634-5797  
2111 West Swann Avenue, Suite 101 ▪ Tampa, Florida 33606 ▪ Phone (813) 251-2525 ▪ Fax (813) 250-9533

PRIVACY PRACTICES ACKNOWLEDGEMENT

Pulmonary Associates of Brandon  
910 Oakfield Dr. Suite 102  
Brandon, FL 33511  
(813) 681-4413

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy at our offices.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosures already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

---

I, \_\_\_\_\_, acknowledge receipt of the Notice of Privacy Practices from Pulmonary Associates of Brandon.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

Pulmonary Associates of Brandon  
910 Oakfield Dr. Suite 102  
Brandon, FL 33511  
(813) 681-4413

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

---

---

---

II. Please list the family members or significant others, if any, whom we may inform about our medical condition ONLY IN AN EMERGENCY:

---

---

---

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

---

---

IV. Please indicate if you want all correspondence from our office to be sent sealed in an envelope marked "CONFIDENTIAL".

\_\_\_\_\_ YES                      \_\_\_\_\_ NO

V. Please print the telephone number where you want to receive all calls about your appointments, lab and x-ray results, or other health care information, if other than your home phone number.

---

VI. Can confidential messages (i.e.: appointment reminders) be left on your telephone answering machine or voicemail?

\_\_\_\_\_ YES                      \_\_\_\_\_ NO

---

Patient Name: \_\_\_\_\_

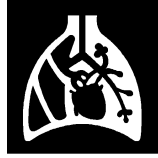
Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Last Update: June 30, 2008

# **PULMONARY ASSOCIATES OF BRANDON**

---

Florida Sleep Disorder Center



Richard S. Powell, M.D.  
DANIEL G. LORCH, M.D.\*  
Thomas P. Hooker, D.O.  
ARTHUR E. GRAVES, M.D.  
SUKETU K. SHAH, M.D.\*

BARBARA A. QUIGLEY, MSN, ARNP-BC

Pulmonary Diseases  
SLEEP DISORDERS  
Critical Care  
INTERNAL MEDICINE

***Diplomat: American Board of Pulmonary Disease; Critical Care; Internal Medicine, Sleep Medicine\****

## **Beginning November 15, 2007**

We will ask for payment at the time of  
service for co-pays, deductibles, and  
estimated amounts of personal payment  
due after insurance.

910 Oakfield Drive, Suite 102 ▪ Brandon, Florida 33511 ▪ Phone (813) 681-4413 ▪ Fax (813) 681-6429  
4051 Upper Creek Drive, Suite 106 ▪ Sun City Center, Florida 33573 ▪ Phone (813) 634-7033 ▪ Fax (813) 634-5797  
2111 West Swann Avenue, Suite 101 ▪ Tampa, Florida 33606 ▪ Phone (813) 251-2525 ▪ Fax (813) 250-9533